

standards laid down under the prevention of Food Adulteration Act is absolutely safe.

(c) Yes, Sir. However, the iodised salt is the most effective, sustainable and cheapest method for prevention and control of Iodine Deficiency Disorders in the Country.

(d) A budget provision of Rs. 15.00 crores has been made during the current financial year 2006-07. It has been estimated that the cost of iodisation of common salt works out to be 10 paise per kg.

(e) Iodisation of salt is liberalized under the Private Sector. The Salt Commissioner, has permitted 824 Private salt manufacturers for the production of iodised salt. The Government is not providing any financial subsidy to the private salt manufactures.

#### **ASHAs under NRHM**

492. SHRI SANTOSH BAGRODIA:  
SHRI HARISH RAWAT:

Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) how many Panchayat level Accredited Social Health (ASHAs) have been enrolled under NRHM, give details thereof, State-wise;

(b) whether any minimum and maximum numbers of ASHAs per Panchayat have been prescribed;

(c) what steps are being taken for the skill upgradation for the Panchayat level ASHAs;

(d) how many ASHAs have been trained since inception of NRHM, give details thereof, year-wise and programme-wise; and

(e) which are the agencies involved in skill upgradation?

THE MINISTER OF STATE IN THE MINISTRY OF HEALTH AND FAMILY WELFARE (SHRIMATI PANABAKA LAKSHMI): (a) The Government of India in April 2005 has launched the NRHM to improve access of people in the rural areas especially the poor women and children to quality primary health care services. Accredited Social Health Activist (ASHA) is an important

strategic intervention under the Mission. The scheme which was initially introduced in only 10 high focus states under NRHM, has now been extended to NE states and tribal areas of other states. A total of 348920 ASHAs have been selected in these areas so far. In addition to ASHAs, 91013 health link workers have also been selected by the States of Andhra Pradesh, Haryana, West Bengal, Karnataka and Chhattisgarh.

State-wise and year-wise details of Selection and Training of ASHA is enclosed at Statement-I and II (See Below)

(b) The general norm is one ASHA for 1000 population. In tribal, hilly, desert areas the norms could be relaxed to one ASHA per habitation, depending on her workload.

(c) Capacity building of ASHA is critical in enhancing her performance. The induction training of ASHA would be completed in 23 days spread in five rounds over a period of 12 months to be followed by periodic re-training for about two days once every alternate month. ASHA training is a continuous one and that she will develop the necessary skills and expertise through continuous on the job training. For the training of ASHA, training modules based on thematic approach have been developed. For this purpose the States have constituted the District Training teams and Block Training teams for training of ASHA. The Block Training teams are providing training to ASHAs.

(d) Till date i.e. 20.2.06, A total number of 225375 ASHAs have been trained. The state-wise position may be seen at Annexure I (Col.6).

(e) At the national level the National Institute of Health & Family Welfare, Munirka is Nodal Agency. At the state level, the state Institute of Health & Family Welfare (SIHFW) with the state training cell of the Dte. of F.W. oversees the processes of training, monitoring and also organizes concurrent evaluation of training programme. Credible NGOs are involved in the training of ASHAs by the Central/State Governments. An ASHA Mentoring Group comprising of leading NGOs in the country set up by GOI advises the Government on selection and Training of ASHAs in the country.

**Statement-I****State-wise Status of ASHA as on 20th February 2007**

State	No. of ASHA proposed for the Mission Period 2005-10	No. of ASHAs selected during 2005-06	No. of ASHAs selected during 2006-07	Total No. of ASHA selected till date	No. of ASHA trained during 2006-07 till date
<b>High Focus Non-NE</b>					
1 Bihar	74313	36488	18663	55151	37495
2 Chhattisgarh	29437	5030	24407	29437	29437
3 Jharkhand	18000	2096	11261	13357	2096
4 Jammu & Kashmir	9500	2773	6565	9338	5093
5 Madhya Pradesh	44379	16090	11266	27356	12816
6 Orissa	47592	12730	16996	29726	12729
7 Rajasthan	42592	20785	11215	32000	23443
8 Uttar Pradesh	123450	19887	91523	111410	8058
9 Uttaranchal	9517	4104	3112	7218	6419
10 Himachal Pradesh	7750	—	—	—	—
<b>TOTAL Non-NE</b>	<b>406530</b>	<b>119983</b>	<b>195008</b>	<b>314991</b>	<b>210586</b>
<b>High Focus NE</b>					
1 Assam	26427	9058	16342	25400	14030
2 Arunachal Pradesh	3862	—	2027	2027	—
3 Manipur	3000	—	2840	2840	—
4 Meghalaya	6180	—	—	—	—
5 Mizoram	943	—	674	674	—
6 Nagaland	2000	—	1309	1309	759
7 Tripura	3902	—	1229	1229	—
8 Sikkim	665	—	450	450	—
<b>TOTAL NE</b>	<b>46979</b>	<b>9058</b>	<b>24871</b>	<b>33929</b>	<b>14789</b>
<b>Non High Focus-Tribal Area</b>					
1 Gujarat	549	—	—	—	—
2 Karnataka	2934	—	—	—	—
3 Maharashtra	9000	—	—	—	—
4 D & N Haveli	250	—	—	—	—
5 Daman & Diu	250	—	—	—	—
6 Lakshadweep	60	—	—	—	—
7 Andhra Pradesh	8500	—	—	—	—
8 Andaman & Nicobar	100	—	—	—	—
<b>TOTAL - TRIBAL AREA</b>	<b>21643</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

**LINK WORKERS in NON-HIGH FOCUS STATES**

	Proposed for the mission period	No. of Link Workers selected during 06-07	Total No. Selected till date	No. Trained till Date
1 Andhra Pradesh	55400	51281	51281	47329
2 Haryana	9000	6966	6966	4078
3 West Bengal	13613	2111	2111	
4 Karnataka	8266	—		
5 Chhattisgarh (Mittanins)	30655	30655	30655	29157
<b>TOTAL:</b>	<b>113934</b>	<b>0</b>	<b>91013</b>	<b>80564</b>

**Statement-II***Details of training of ASHA***Training**

Capacity building of ASHA is critical in enhancing the effectiveness. It has been envisaged that the training will help to equip her with necessary knowledge and skills resulting in achievement of the Schemes objectives. Capacity building of ASHAs has been seen as a continuous process.

**Training Strategy**

- \* **Induction Training:** After selection, ASHA will have to undergo series of training episodes to acquire the necessary knowledge, skills and confidence for performing her spelled out roles. Considering range of functions and tasks to be performed, induction training may be completed in 23 days spread over a period of 12 months. The first round may be of seven days, to be followed by another four rounds of training, each lasting for four days to complete induction training.
- \* **Training Materials:** Would be prepared according to the roles and responsibilities that the ASHA would need to perform. Her envisaged functions and task will be expanded into a listing of competencies and the training material would be prepared accordingly. The training materials produced at the national level would be in the form of a general prototype which states may

modify and adapt as per local needs. The training materials will include facilitators guide, training aids and resource material for ASHAs.

- \* **Periodic Trainings:** After the induction training, periodic re-training will be held for about two days, once in every alternate month at appropriate level for all ASHAs. During this training, interactive sessions will be held to help refresh and upgrade their knowledge and skills, trouble shoot problems they are facing, monitor their work and also for keeping up motivation and interest. The opportunity will also be used for replenishments of supplies and payment of performance linked incentives. ASHA will be compensated for attending these meetings.
- \* **On-the-job Training:** ASHAs need to have on the job support after training both during the initial training phase and during the later periodic training phase it is needed to provide on the job training to ASHAs in the field, so that they can get individual attention and support that is essential to begin and continue her work. ANMs while conducting outreach sessions in the villages will contact ASHA of the village and use the opportunity for continuing education. NGOs can also be invited to take up the selection, training and post training follow up. Similarly block facilitators identified earlier for selection of ASHAs can also be engaged for regular field support.
- \* **Training of Trainers:** A cascade model of training is proposed. At most peripheral level, Block trainers (who are the members of identified block training teams) would have to spend at least the same number of days in acquiring the knowledge and skills as ASHAs. These ToTs will also have to be similarly phased. These trainers should be largely women and chosen by block nodal officer. The block teams would be trained by a district trainer's team. (Or Master trainers) who are in turn trained by the State training team. The duration to ToTs for District Training Teams (DTT) and State Training Teams (STT) will be finalised by the States depending on the profile of the members to be selected as DTT and STT.
- \* **Constitutions of Training Teams:** It follows that each State, District and Block would have a training team comprising of

three-four members. Existing NGOs especially those working on community health issues at the district/block level may also be entrusted with the responsibility for identifying trainers and conducting of ToTs. The trainers would be paid compensation for the days they spend on acquiring or imparting training—both camp based training and on the job training. The similar guidelines applies to the district level also where trainers would be drawn in from programme Managers and NGOs. The State Institutes of Health and FW alongwith reputed and experienced NGOs would form training teams at the State Level. State level training structures to be used for trainings under various National Health and FW programmes Trainings may be adhered wherever feasible.

- \* **Continuing Education and Skill Upgradation:** A resource agency in the district of State (Preferably an NGO) will be identified by the State. The resource agency in collaboration with open schools and other appropriate community health distance education schemes will develop relevant illustrated material to be mailed to ASHAs periodically for those who would opt for an eventual certification.
- \* **Venue of Training:** The principle of choice of venue shall be that the venue should be close to their habitation that the training group should not be more than 25 to 30. In most situations this could be the PHC or alternatively Panchayat Bhavan or other facilities that are available.
- \* **National Level:** At the National Level the National Institute of Health and FW (NIHFW) would in coordination with the National Rural Health Mission and its technical support teams and the Training Division of the Ministry will coordinate and organise periodic evaluation of the training programmes. The findings of these concurrent evaluations should be shared with State Governments.
- \* **State Level:** At the State Level, the State Institute of Health and FW (SIHFW) in coordination with the State Training Cell of Directorate of Family Welfare will oversee the process of training, monitor and organise concurrent evaluation of training programme.